Alabama Medicaid Agency

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DON SIEGELMAN
Governor

MIKE LEWIS
Commissioner

April 9, 2001

Provider Notice 01-06

TO: Medicaid Physicians, Pharmacies, FQHCs, RHCs and Nursing Homes

RE: Proton Pump Inhibitor (PPI) Prior Authorization

Effective May 9, 2001, the Alabama Medicaid Agency will require prior authorization for payment of Proton Pump Inhibitors (PPI). The attached form should be utilized by the prescribing physician or the dispensing pharmacy in requesting prior authorization. Requests may be faxed, or mailed to:

Health Information Designs (HID)
Medicaid Pharmacy Administrative Services
P. O. Box 3210
Auburn, AL 36832-3210
Fax: 1-800-748-0116
Phone: 1-800-748-0130

PA requests failing to meet Medicaid criteria will be denied. If the prescribing physician believes medical justification should be considered, the physician must submit a written letter of medical justification along with the prior authorization form. Additional information may be requested. Staff physicians will review this information.

Policy questions concerning this provider notice should be directed to Louise F. Jones, Associate Director, Program Management at 334-242-5039. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

Mike Lewis
Commissioner

Distribution:

Alabama Independent Drugstore Association	Alabama Pharmacy Coop	State of Alabama Medical Association
Alabama Pharmacy Association	Alabama Retail Association	Medical Association of the State of Alabama
Alabama Primary Healthcare Association	Alabama Nursing Home Association	Alabama Optometric Association

Proton Pump Inhibitors (PPIs)
Prior Authorization Request Form

FAX OR MAIL TO:

Health Information Designs, Inc.
P.O. Box 3210
Auburn, AL 36832-3210
Phone: (800) 748-0130 Fax: (800) 748-0116

****NOTE: OTC and generic H2 Antagonists do not require prior authorization**

Patient Information

Patient Name: _____ Medicaid #:_____
Phone #: ( )_____ Date of Birth:_____

Prescriber Information

Provider Name: _____ License #:( )_____
Address: _____ Phone #: ( ) _____
City/State/Zip: _____ FAX #: ( )_____
*Signature _____ Date _____

Pharmacy Information

Pharmacy Name: _____ Provider #: _____
NDC #: _____FAX #: ( ) _____ Phone #: ( ) _____

Drug/Clinical Information

Brand Drug Requested: _____ Strength/Quantity:_____
Proposed duration of therapy: _____ Daily Dose:_____

Indicate prior antacid, OTC/generic/brand H2 antagonist, PPI or prokinetic drug used :

(1) Name of drug: _____ Dates of therapy:_____
- Reason for discontinuation: _____

(2) Name of drug: _____ Dates of therapy:_____
- Reason for discontinuation: _____

Please check only one: **Acute therapy** **or** **Maintenance therapy**

Indicate the relevant diagnosis **and** the results of any testing done:

Peptic Ulcer Disease	**Type of Testing:**	**Yes**	**No**
Duodenal Ulcer	H. pylori	(positive)	(negative)
Gastric Ulcer	Breath		
Bleeding Ulcer	Serologic		
Unknown location	Biopsy		
GERD	UGI/Barium swallow		
Heartburn/Dyspepsia	Endoscopy		
Esophagitis, erosive	pH monitoring		
Esophagitis, non-erosive	No Testing done		
Barrett's Esophagus			
Zollinger-Ellison Syndrome	Combination Therapy for H. pylori _____		
Other hypersecretory condition(s)	_____		

Specify_____

*For heartburn/dyspesia, patient **must** have documentation of a minimum of 8 weeks of therapy with OTC/generic/brand H2 antagonist **and** an antacid with documentation of unresponsiveness.*

*If no testing performed, patient **must** have documentation of a minimum of 8 weeks therapy with antacid, OTC/generic/brand H2 antagonist, PPI or prokinetic drug used and failure for acute therapy.*

If H. pylori positive (+) indicate combination therapy being used above.

***Supporting documentation must be available for review upon request**

FOR HID USE ONLY: **MEDICAID ELIGIBILITY VERIFIED**

Approve request Deny request Modify Request

Authorization effective dates from _____ through _____

Comments: _____

_____ _____

Reviewer's Signature Response Date/Hour